UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

GROWTH HORMONE (Children 0-18 years)

Patient name:_____Medicaid or SS#_____
Physician Name:_____ Contact person:_____
Phone#:_____Ext and options_____Fax#_____
Pharmacy_____Pharmacy Phone#:_____
Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX REQUIRED DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- Approved for ages 0-18, must have started before age 16.
- Must have a height stature less than the 5th percentile on the PHYSICAL GROWTH NCHS PERCENTILES CHART for correct age and sex.
- Growth rate must be documented in centimeters for a least 6 months immediately before initiation of growth hormone treatment.
- **ONE** of the following diagnosis:

  *Documented endogenous growth hormone secretion of <10ng.ml after provocative stimulation OR

  *Growth failure associated with documented chronic renal insufficiency up to the time of renal OR transplantation.

  *Long - term treatment of idiopathic short stature, also called non-growth hormone-deficient short stature, defined by height SDS (Standard Deviation) <2.25 (Humatrope) OR

  *Treatment of short stature associated with Turner Syndrome in patients whose epiphysis are not closed OR

  *Treatment of short bowel syndrome in patients receiving specialized nutritional support OR

  *Panhypopituitarism
- Completed sleep oximetry study for clients with Prader Willi. If the oximetry is abnormal, a full polysomnography study is required. GH is contraindicated in patients with sleep apnea - PA will not be granted to clients that have sleep apnea.
- Prescribed by endocrinologist or with endocrinology consultation.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Fax pt's wt in kilograms, ht. in centimeters, and current prescription. Treated growth rate must exceed untreated rate by 2 centimeters per year.

CRITERIA: Section II SMALL GESTATIONAL AGE (SGA)

- Request must be made before age three
- Child has normal GH blood levels (May have documented GH resistance)
- Must be under the care of or have extensive endocrinologist consultation.
- A copy of the prescription signed by the physician must be submitted with application.

AUTHORIZATION:

1 year. Maximum covered time period: 2 years

RE-AUTHORIZATION:

Fax copy of current prescription and history and physical showing growth in past year.